



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

James Bales, M.D.

Respondent Name

Insurance Company of the West

MFDR Tracking Number

M4-17-2488-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

April 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EOB shows payment for two body parts. D. Bales addressed four parts..."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the services rendered an additional allowance was made for the non-muscular body area of the nervous system for the Eye in the amount of \$150.00.

Per Medical Fee Guideline for Workers' Compensation Specific Services Pursuant to DWC Rule §134.204 allowances were made for MMI at \$350, Impairment Rates time 3 body areas \$600, Multiple Impairment Rating \$50 and Extent of Injury \$500 for a total allowance of \$1500.00."

Response Submitted by: Mitchell International, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2016	Designated Doctor Examination	\$300.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work and evaluation of medical care examinations performed on or after September 1, 2016.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 790 (P12) – Workers’ compensation jurisdictional fee schedule adjustment.
 - Notes: “Only 2 body parts (not 10 units) – Cervical Spine (Spine and Pelvis) and Shoulder, Biceps (Upper Extremities and hands) - \$300 for first body part and \$150 for Second body part for a total of \$ 450.00. \$350 for doing the MMI test is paid in full on line #1 at \$350.00.”

Issues

Is James Bales, M.D. entitled to additional reimbursement for the disputed services?

Findings

Dr. Bales is seeking an additional reimbursement of \$300.00 for a designated doctor examination to determine maximum medical improvement, impairment rating, and extent of injury performed on November 14, 2016.

Per 28 Texas Administrative Code §134.235,

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier ‘RE.’ In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports...

The submitted documentation indicates that Dr. Bales performed an examination to determine the extent of the compensable injury. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$500.00.

Per 28 Texas Administrative Code §134.250(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456.

Reimbursement shall be \$350.” The submitted documentation supports that Dr. Bales performed an evaluation of maximum medical improvement. Therefore, the MAR for this examination is \$350.00.

28 Texas Administrative Code §134.250(4) states:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
 - (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
 - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
 - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of cervical and thoracic strain, right shoulder strain and capsulitis, right orbital blowout fracture, right eye hypertropia, alternating intermittent extropia, diplopia, enophthalmos, TMJ, facial neuropathic pain, loose teeth, and anomaly of jaw-cranial base relationship.

The MAR for this examination is calculated as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
IR: Cervical/Thoracic Spine (ROM)	Musculoskeletal System	Spine & Pelvis	\$300.00
IR: Right Shoulder (ROM)		Upper Extremities	\$150.00
IR: Right Orbital Fracture	Visual System	Body Systems	\$150.00
IR: Right Eye			
IR: Jaw/Teeth	Ear, Nose, Throat & Related Structures	Body Structures	\$150.00
Total Impairment Rating			\$750.00

28 Texas Administrative Code §134.250(4)(B) states,

When multiple IRs are required as a component of a designated doctor examination ... the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

The submitted documentation indicates that Dr. Bales performed examinations to address maximum medical improvement, impairment rating, and extent of injury, and an additional impairment rating was provided. Therefore, the MAR for this service is \$50.00.

The total reimbursement for the disputed services is \$1,650.00. Insurance Company of the West asserted that it paid a total of \$1,500.00. Documentation submitted to the division supports that Insurance Company of the West reimbursed \$1350.00. Therefore, an additional reimbursement of \$300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 23, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.